ORGANIZATION FOR LONG-TERM MANAGEMENT OF HYPERTENSION: INTRODUCTION*

MICHAEL H. ALDERMAN, M.D.

Associate Professor of Public Health
The New York Hospital-Cornell Medical Center
New York, N.Y.

HYPERTENSION is a unique medical disease. More common than almost any other illness, it can be diagnosed simply and accurately and responds to safe treatment with a substantial reduction in cardiovascular sequelae. Although a clear understanding of causality, except for a small percentage of cases, has proved elusive, the practical capacity to intervene is available. Thus, while medical scientists continue the search for etiology, the clinician already possesses the means to improve the prognosis for the vast majority of hypertensive citizens.

Unfortunately, however, available evidence indicates that most hypertensives are not treated satisfactorily. There has been substantial discussion about why this has been so, but its focus has been almost exclusively on quantitative aspects of the problem. Statistics have been marshalled to demonstrate that facilities for screening, diagnosis, and long-term treatment are insufficient. The result has been to obscure the fundamental issue. The cause of untreated hypertension is not simply a quantitative inadequacy, but represents a qualitative shortfall as well. There is no evidence that expansion of the existing structure for the delivery of health care would reduce the burden of undiagnosed, untreated, and uncontrolled hypertension. Indeed, most patients with moderate hypertension who are involved in the current system do not have their hypertension controlled. The traditional clinical model for the delivery of medical care, involving the personal encounter of one physician and one patient, does not seem to be the right method for treating the essential "well" patient who may be advised to commit himself to decades of treatment.

This section of the conference will describe a new system of health-care

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delivery designed specifically to meet the long-term needs of asymptomatic working adults with hypertension. Its design has not been limited by the constraints of the traditional pattern of care. Instead of asking the patient to come to the doctor's office or hospital clinic, care is delivered to the patient where he works. Standardized, not individualized, therapy is provided by a team led by a physician who therefore becomes not only a participating clinician but also the program supervisor. Integration of the health-care delivery system within the functionally cohesive social structure of the trade union is a basic concept of this program.

The following three papers wil describe the team approach, the role of the physician, and the program's relation to the trade union structure. The material to be presented relates to an occupationally based hypertension detection and treatment program which was initiated among members of the United Storeworkers Union and subsequently was expanded to include members of New York City Municipal Employees DC37. Although the discussion is somewhat specific, the over-riding principles should be easily recognized and are appropriate for widespread replication.